Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: PALLADIUM FOR SURGERY DALLAS, LTD 5920 FOREST PARK RD #700 DALLAS, TX 75235	MFDR Tracking #: M4-09-B419-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TRAVELERS INDEMNITY CO REP BOX #: 05	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary taken from Table of Disputed Services: "Billed timely and pmt is due"

Principal Documentation:

1. DWC060
2. Hospital or Medical Bill(s)
3. EOB(s)
4. Medical Reports
5. Total Amount Sought $2263.40

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The Provider's billing for the services was subsequently received by the Carrier on 06-17-2008, which is also the signature date of the bill. This submission date is 141 days after the date of service. Therefore, the Provider's billing was not timely submitted in accordance with Rule 133.20(b) requiring submission of the medical bill within 95 days of the date of service. … Finally, this Request for Medical Dispute Resolution should be dismissed, as it was not timely filed. Under Rule 133.307(c)(1)(A), for fee disputes with no contest of compensability or relatedness, the Request must be filed within one year of the date of service. For this dispute, the Provider's Request for Medical Dispute Resolution was due to be filed with the Division of Workers' Compensation no later than 01-22-2009. As demonstrated by the Division's received stamp, the Request was received 07-24-2009. It is therefore untimely, and should be dismissed in accordance with Rule 133.307(e)(3)(E)."

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Calculations	Amount in Dispute	Amount Due
01/22/08	28465, 27658, 29405	N/A	$2263.40	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 07/11/2008 noted claim reduction code:
   - 29 – The time limit for filing has expired.
   - W1 – Workers Compensation state F/S Adj.

3. Explanation of benefits dated 01/07/2009 noted claim reduction code:
   - W4- No additional reimbursement allowed after review of appeal/reconsideration. Appeals will not be considered after the First day of the 11th Month.

Issues

1. Did the requestor file for dispute resolution in accordance with 28 Tex. Admin. Code §133.307?
2. Is this request eligible for medical fee dispute resolution under 28 Tex. Admin. Code § 133.307?

Findings

1. 28 Tex. Admin. Code §133.307(c)(1)(A) states in pertinent part that a request for medical dispute resolution (MDR) shall be filed no later than one year after the date(s) of service in dispute. The date of service in dispute is 01/22/2008. The request for dispute resolution was received in the MDR section on 07/24/2009.
2. Pursuant to 28 Tex. Admin. Code §133.307(c)(1) states that a requestor shall timely file with the Division's MDR section or waive the right to medical dispute resolution. Because no documentation was found to support timely filing of the medical fee dispute, the requestor waived their right to fee dispute resolution.

Conclusion

For the reasons stated above, the division finds that the requestor has waived the right to medical fee dispute resolution. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §408.021, §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

		07/20/10
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.